

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1934	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2010
NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies Based on observation during the annual Licensure Life Safety Survey, it was determined, there were no fire safety deficiencies noted.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0890

ECRM21

TITLE

(X6) DATE

3/12/10

If continuation sheet 1 of 1

MAR 15 2010